

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152024		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/24/2012	
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	<p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00104391</p> <p>Substantiated with deficiencies cited both related and unrelated to the allegations</p> <p>Date: 7/23/12 and 7/24/12</p> <p>Facility Number: 003767</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>QA: claughlin 08/13/12</p>			S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0536	<p>410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1 (d)(1)(2)(3)</p> <p>(d) Menus shall meet the needs of the patients as follows:</p> <p>(1) Therapeutic diets shall be prescribed by the practitioner responsible for the care of the patient.</p> <p>(2) Nutritional needs shall be met in accordance with recognized dietary standards of practice and in accordance with the orders of the responsible practitioner.</p> <p>(3) A current therapeutic diet manual approved by the dietitian and medical staff shall be readily available to all medical, nursing, and food service personnel.</p> <p>Based on patient medical record review and staff interview, the registered dietitian failed to write orders for supplemental feedings that the dietitian documented as being provided to 2 of 5 patients. (pts. N1 and N4)</p> <p>Findings:</p> <p>1. Review of medical records during the survey process indicated:</p> <p>a. pt. N1 had RD (registered dietitian) notes of 2/3/12 that indicated the patient was to have supplemental feedings with "Glucerna shakes BID", but lacked an order by the RD for the nutritional feedings</p> <p>b. pt. N4 had RD notes on 2/3/12 that read: "Oral supplements: Ensure Plus...", and on 2/16/12 that indicated: "Plan: 1. Continue with Regular diet/Ensure Plus daily...", but lacked an order by the RD for nutritional feedings</p>			S0536	<p>1.). The Chief Nursing Officer (CNO) has provided education to the RD regarding this process</p> <p>2.). The Medical Director will provide education to the Medical Staff in the form of a letter on the process change.3.) The Registered Dietician (RD) will see every patient and complete an assessment within 72 hours of the patient's admission. Based on the assessment, nutritional supplements may be recommended if indicated. 4.) Orders will be written for the supplemental feedings by the Medical Staff. 5.) Chart audits will be conducted by the CNO or designee to assure continued compliance with this standard. The audits will be conducted as</p>		08/24/2012

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	<p>2. at 10:15 AM on 7/24/12, interview with the dietitian, ND, indicated:</p> <p>a. RD staff can write orders for patient diets and supplements per facility protocols that have been approved by the medical staff</p> <p>b. patients N1 and N4 are lacking orders by the RD for the supplements that are indicated in their reports as being recommended by the RD</p>			<p>follows:</p> <ul style="list-style-type: none"> ·30 charts per month or 100% of admissions, for 4 months if less than 30. In a month ·# of recommended supplements ordered/ # of dietary consults with recommendations for supplements ·Results of the audit will be reported to the QAPI Committee, the Organization Improvement Committee the Medical Executive Committee and the Governing Board <p>6.) The responsible person for the plan of correction is the CNO withthe DQM.</p>			

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S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on patient medical record review and staff interview, the nurse executive failed to ensure that nursing staff followed physician orders for daily and weekly weights for 4 of 5 patients (N1, N2, N4, and N5), failed to follow up on drastic fluctuations in documented patient weights for 2</p>			S0912	<p>1.) The CNO provided education to the nursing staff regarding the requirements for the documentation of patient weights,</p>		09/21/2012

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	<p>of 5 patients (N1 and N3), failed to document the percent of each meal consumed by the patient for 3 of 5 patients (N1, N4 and N5), and failed to document supplemental feedings and amounts consumed for 1 patient (N1).</p> <p>Findings:</p> <p>1. review of patient medical records indicated a lack of following physician orders related to weights as follows:</p> <p>a. pt. N1 had physician orders on admission for daily wts but was lacking such documentation for 9 of 34 days of hospitalization</p> <p>b. pt. N2 had physician orders on admission for daily wts but lacked documented weights for 3 of 26 days of hospitalization</p> <p>c. pt. N4 had physician orders on admission for daily wts but lacked documented weights for 13 of 18 days of hospitalization</p> <p>d. pt. N5 had physician admission orders for a wt. every 7 days and lacked a documentation of wt on 2/7/12 (one wt missed)</p> <p>2. review of patient medical records indicated drastic fluctuations in weight (without any follow up) as indicated:</p> <p>a. pt. N1 had an admission wt. on 2/2/12 of 149.3#--was noted as 156.8# on 2/9/12 and then had documentation on 2/11/12 of a wt. of 124.5#--on 2/19/12, the patient's wt was noted as 160.6#--RD (registered dietitian) documentation noted the discrepancy and inaccuracies, but nursing failed to note any follow up related to these weight changes</p> <p>b. pt. N3 had an admission wt. noted as 148.7# on 2/21/12--on 2/22/12, nursing charted a wt of 168.7#, then on 2/23/12 a wt of 141.4# was written in the medical record---RD documentation noted the discrepancy and inaccuracies, but nursing failed to note any follow up related to these weights</p>				<p>nutritional supplements and amount of a meal consumed. Documentation requirements are also addressed daily during Safety Huddles. Staff has also been provided with a copy of policy D05-G, Documentation Standards and NO2-N, Nursing Care Plan for review. A record of staff receiving this education will be retained as a part of this action plan. 2).The patient will be weighed according to the physician order. In the event there is a discrepancy, the patient will be re-weighed. The results of the patient weight will be documented on the 24 Hour Nursing Flow Sheet.3.) The attending physician will be notified of the weight change.4.) Chart audits will be completed by the CNO, DQM or designee to assure that weights, nutritional supplement intake and meal intake is documented in the medical record and to assure compliance with this standard. The audits will be conducted as follows:</p> <ul style="list-style-type: none"> ·30 patient records or 100% of all admissions, if less than 30 for four months ·# of patient weights documented appropriately / # of patient weights ordered ·# of patients with all meals and supplements documented / # of patient charts audited ·Results of the audit will be reported to the QAPI Committee, the Organization Improvement Committee the Medical Executive 		

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	<p>3. review of the medical records indicated a lack of documentation by nursing staff on the "24 hour Patient Record and Plan of Care" form related to the amount/percent of each meal eaten as follows:</p> <p>a. pt. N1:</p> <p>A. was lacking notation for 11 of 34 days as to the percent eaten for at least one meal each day</p> <p>B. was lacking documentation of the type of supplement the patient was to receive (or was ordered by the physician/dietitian) and how much, if any, of the supplelement was consumed with each offering</p> <p>b. pt. N4:</p> <p>A. had 9 of 18 days that nursing staff failed to note the percent of each meal eaten by the patient for at least one meal/day</p> <p>B. lacked documentation by nursing staff of the type of nutritional supplement the patient was taking and the amount of the supplement, if any, was consumed with each offering</p> <p>c. pt. N5 was lacking documentation for 10 of 12 days related to the amount/percent eaten for at least one meal/day during the hospitalization period</p> <p>4. review of the medical records indicated that the supplement ordered on 2/15/12 ("Add ensure 1 can TID") by the physician for pt. N1 was never noted by nursing staff as having been given to the patient</p> <p>5. Interview with the chief nursing officer, staff member NC, and the dietitian, staff member ND, at 10:45 AM on 7/24/12 indicated:</p> <p>a. the physician ordered ensure TID for pt. N1 on 2/15/12, but there is no documentation by nursing staff that indicates this order was completed---no documentation related to the offering of the supplement, or the amount consumed, if any</p> <p>b. the dietitian noted drastic fluctuations in wt by nursing staff for patients N1 and N3, and at times</p>				<p>Committee and the Governing Board.</p> <p>The CNO is the responsible prty for this corrective action plan.</p>		

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	asked for the patient to be re weighed for accuracy c. there are often inconsistencies in wts noted by the dietitian when doing follow up with patients d. it was confirmed that daily wts and weekly wts were lacking as written above e. it was confirmed that staff is not documenting the amount eaten at meals, as expected by the chief nursing officer, on the 24 hour form						